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A CASE REPORT ON CARCINOMA ENDOMETRIUM

Obstetrics & Gynaecology

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ABSTRACT

Endometrial carcinoma (EC) represents the most common malignancy of the female reproductive tract in developed countries, with an incidence rate of approximately 25 cases per 100,000 women annually [1]. Endometrial papillary serous adenocarcinoma (EPSA), a highly aggressive subtype, often presents with lympho vascular invasion, contributing to its poor prognosis. This is a case report of a 48years old female who had a history of right carcinoma breast for which Modified Radical Mastectomy(MRM) with axillary clearance was done followed by 6 cycles of chemotheraphy . History of left side mastectomy done in 2005 in view of carcinoma of left breast followed by Bilateral salpingo-oophorectomy done on 7/7/2011 and was started On tamoxifen 10mg bd since 10 years attained surgical menopause since 12 yrs came ,she came to our gynaecological out patient department(OPD) with complaints of spotting per vagina since 1 week . Pipelles done showed papillary adenocarcinoma of endometrium . Patient was diagnosed as a case of CA endometrium stage III for which staging laparotomy was done.

KEYWORDS

Endometrial cancer, carcinoma breast, surgical menopause, staging laparotomy

INTRODUCTION

Endometrial cancer is the fourth most common cancer among women in developed countries and is the most frequently diagnosed gynecologic cancer. Endometrial papillary serous adenocarcinoma (EPSA) is a rare and aggressive subtype of endometrial cancer. It accounts for approximately 10% of endometrial cancers but is responsible for a disproportionate number of deaths due to its aggressive nature and tendency to present at an advanced stage[1]. Diagnosis is typically made through a combination of pelvic examination, imaging studies (such as ultrasound), and endometrial biopsy .Despite advancements in surgical and adjuvant therapies, the prognosis for advanced-stage or recurrent disease remains poor[3]

CASE REPORT:

Mrs.Y, 48years old female married since 22 years ,para 3 live 3 abortion 2 ,full term normal vaginal delivery, sterilized ,last child birth-18 years back, surgical menopausal since 12years , known case of Type2diabetes mellitus on oral hypoglycemic drugs and Insulin, newly diagnosed Hypertension on treatment ,came with complaints of spotting per vaginum since 1 week, no complaints of abdominal pain, mass descending pervagina or postcoital bleeding.

MRI PELVIS done outside showed , uterus normal size with thickened endometrium(25mm) and minimal enhancement, junctional zone appears normal. Previous history of MRM with AXILLARY CLEARANCE done for right breast (indication-ca breast) followed by 6 cycles of chemotheraphy and left mastectomy done in 2005, history of lap Bilateral salpingo-oophorectomy done on 7/7/2011. On tamoxifen 10mg bd since 10 years.

PIPELLES Sampling with cervical biopsy done(2/11/22) showed Papillary Adenocarcinoma of Endometrium.

PET SCAN DONE SHOWED:

Bilateral mastectomy status with axillary clearance

Intensely hypermetabolic diffuse endometrial thickening with possible infiltration of the inner half of the myometrium-ENDOMETRIAL CARCINOMA T1a.

Per abdomen:

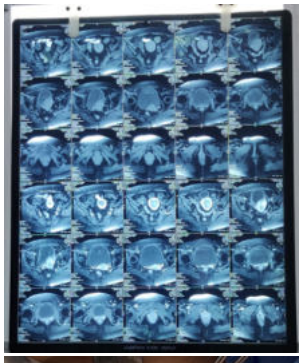
soft non tender ,laparoscopic scar+,per speculum: cervix healthy, per vaginum: cervix pointing downwards, uterus anteverted normal size fornices free,non tender.

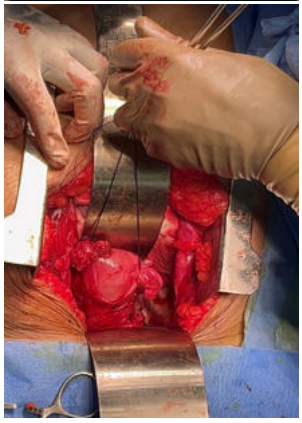
Patient was diagnosed as a case of Carcinoma Endometrium stage III

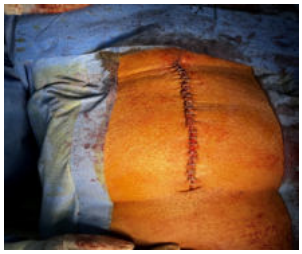
After obtaining general medicine opinion ,radiation and medical oncologist patient , patient was electively taken up for TYPE II HYSTERECTOMY WITH BILATERAL PELVIC LYMPHADENOPATHY ON 22/11/22.

Intra Op Findings:

Uterus normal size, bilateral tubes and ovaries absent.no ascitic fluid Procedure proceeded in usual manner, uterus removed followed by bilateral pelvic lymphadenectomy done and sent for Histopathological examination.







Post Operatively:
patient stable , resumed normal bowel and bladder movements radiation and medical oncologist opinion obtained in view of Histopathology report showing ENDOMTERIAL PAPILLARY SEROUS ADENOCARCINOMA WITH LYMPHOVASCULAR INVASION.

Patient was started on systemic chemotheraphy 3 cycles followed by Adjuvant Radiotheraphy and Adjuvant chemotheraphy and recovered soon.

DISCUSSION:
Endometrial cancer may be detected through a variety of means[4]. Today, the endometrial biopsy is the most common technique used to obtain endometrial tissue, and evaluation of endometrial histology has been the gold standard for determining the status of the endometrium[4]

Tamoxifen is a selective oestrogen receptor modulator (SERM) used for treatment and prevention of breast cancer[5]. Its inhibitory action in the breast is stimulatory in the endometrium and responsible for a four-fold increased risk of EC in postmenopausal long-term users[6].

The effect of estrogens in the pathogenesis of endometrial cancer has been proved by several epidemiological studies. The strong association of endometrial cancer with long-term unopposed estrogenic action, either exogenous or endogenous, in women with an intact uterus has been postulated to be causative. Unopposed estrogens lead to increased mitotic activity of endometrial cells, resulting in more frequent errors in DNA replication and somatic mutations. These changes are manifested clinically as hyperplasia and carcinoma. However, the carcinogenic effect of estrogen on endometrium i to some extent is opposed by effect of progesterone.

CT Chest/abdomen/pelvis is recommended for staging of high-grade endometrial cancer[7].

MRI pelvis (+/- abdomen) may be helpful to assess extent of loco-regional disease and estimate depth of myometrial invasion, if results would direct location of surgery and management of lymph nodes[7].

CONCLUSION:
The prognosis of endometrial cancer is generally good if diagnosed early, with a high five-year survival rate for early-stage cancer. However, advanced-stage cancer has a poorer prognosis and requires more aggressive treatment. Maintaining a healthy weight, managing risk factors, and regular gynecological check-ups are important for early detection and prevention. Awareness of symptoms and prompt medical consultation for abnormal bleeding can lead to early diagnosis and better outcomes.

REFERENCES:

1.) Hamilton, C.A., Cheung, M.K., Osann, K., Chen, L., Teng, N.N., Longacre, T.A., ... & Kapp, D.S. (2006). Uterine papillary serous carcinoma: an analysis of 1,895 cases from the National Cancer Database. Gynecologic Oncology, 103(2), 719-726.
2.) Kandoth, C., Schultz, N., Cherniack, A. D., Akbani, R., Liu, Y., Shen, H., ... & Levine, D. A. (2013). Integrated genomic characterization of endometrial carcinoma. Nature, 497(7447), 67-73. doi:10.1038/nature12113
3.) Gynecologic Oncology, University of North Carolina at Chapel Hill, NC, USA,recent advances in endometrial cancer, doi: 10.12688/f1000research.10020.1
4.) Endometrial Cancer Holland-Frei Cancer Medicine. 6th edition by Robert A. Smith, PhD, Curtis J. Mettlin, PhD, and Harmon Eyre, MD.
5.) British Gynaecological Cancer Society (BGCS) uterine cancer guidelines: Recommendations for practice by Jo Morrison a, Janos Balega b, Lynn Buckley c, Andrew Clamp d, Emma Crosbie e, Yvette Drew f, Lisa Durrant g, Jenny Forrest h, Christina Fotopoulou i, Ketan Gajjar j, Raji Ganesan k, Janesh Gupta l, John Hughes m, Tracie Miles n, Esther Moss o, Meenu Nanthakumar p, Claire Newton q, Neil Ryan q r, Axel Walther s, Alexandra Taylor t https://doi.org/10.1016/j.ejogrb.2021.11.423
6.) British Gynaecological Cancer Society (BGCS) uterine cancer guidelines: Recommendations for practice by Esther Moss 2022, European Journal of Obstetrics & Gynecology and Reproductive Biology.
7.) British Gynaecological Cancer Society (BGCS) Uterine Cancer Guidelines: Recommendations for Practice by Jo Morrison , Janos Balega , Lynn Buckley , Andrew Clamp , Emma Crosbie , Yvette Drew , Lisa Durrant, Jenny Forrest , Christina Fotopoulou , Ketan Gajjar, Raji Ganesan , Janesh Gupta , John Hughes , Tracie Miles, Esther Moss , Meenu Priyadarshini Nanthakumar , Claire Newton , Neil Ryan, Axel Walther, Alex Taylor